American Medical Association
Physicians dedicated to the health of America

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The Honorable Thomas J. Bliley, Jr.
Chairman
House Committee on Commerce
2 125 Rayburn House Office Building
Washington, DC 205 15

Dear Chairman Bliley:

The American Medical Association (AMA) is writing in response to your recent request to answer questions regarding the National Practitioner Dank Bank (NPDB) (see attachment).

The AMA shares your commitment to ensure that "consumers have the ability and the access to choose the best quality health care available." Indeed, improving quality and providing patients with increased access to health care are high priorities for the AMA. We will continue work with Congress, the Administration state and specialty medical societies, and the private sector to address the problems in our health care system associated with access, restrictions on patients' choice of physicians, managed care fairness, expanding health insurance coverage, reducing health system errors, and improving the quality of health care.

The AMA supports the goal of preventing physicians from moving state to state or hospital to hospital without disclosure of adverse peer reviewed actions taken against them. We respectfully disagree, however, that the NPDB is a mechanism by which information on physicians and other health care providers should be disseminated to the public. Congress simply did not design the NPDB to provide information to the public in a format that would assist patients. In fact, the House Committee on Energy and Commerce (now the Commerce Committee) emphasized such in its Committee Report (Rept. 99-903) on the Health Care Quality Improvement Act of 1986. In addition public dissemination would be explicitly contrary to Sections 402 (Findings) and 427(b) (Confidentiality of Information) of the statute.

The AMA encourages you to review the recently released report by the Institute of Medicine (IOM) entitled, "To Err is Human, Building a Safer Health System." The IOM report recommends an approach to reducing errors in which punitive efforts are rejected and efforts to create a "culture of safety" are recommended. We agree, and believe it is necessary for the health system, state and federal governments, and society to transform our culture of blame and punishment that suppresses information about errors into a culture of openness and information-sharing that will lead to understanding and error prevention.

Even before the IOM report was proposed, the AMA was pioneering the effort to reduce health care system errors and ensure that our patients receive safe, quality health care. For example, in 1996, the American Association for the Advancement of Science, the Joint Commission on Accreditation of Healthcare Organizations, and the AMA joined with the Annenberg Center

for Health Sciences to convene the first multidisciplinary conference on errors in health care. As a result of that conference, several initiatives in patient safety are being undertaken at the state and national level, such as preventing patient injuries due to medication errors.

Also, recognizing the importance of reducing health care system errors and the imperative for physician leadership, in 1997 the AMA established the National Patient Safety Foundation (NPSF), a broad-based partnership of health care clinicians, consumer advocates, health product manufacturers, public and private employers and payers, researchers, regulators, and policymakers. The NPSF is now an independent not-for-profit organization. Working collaboratively with its broad base of constituents, the NPSF is leading the patient safety movement by raising awareness, building a knowledge base, creating a forum for sharing knowledge, and facilitating the implementation of practices that improve patient safety. Two examples of the NPSF's progress include the Pharmaceutical Safety Initiative to reduce the risk of medication errors, and the Solutions Project that focuses on sharing best practice clinical examples that have improved safety with measurable outcomes.

The AMA believes that true reform must encompass all components of the health care system and not focus only on individual components. Hospitals, physicians, nurses, pharmacists, drug and device manufacturers, nursing homes, health plans and insurers, and others must all work together and be encouraged to work together to identify, study, and solve system-wide problems that could cause errors. Our common goal must be to detect errors and system barriers to make corrections before a patient is harmed. Reporting errors in this way enhances research, which ultimately leads to error prevention.

The AMA appreciates the opportunity to respond to your questions regarding the NPDB, and we hope that the IOM report will provide you with an alternative perspective on improving the quality of our health care system and the safety of our patients.

Respectfully,

E. Ratcliffe Anderson, Jr., MD

attachment

cc: The Honorable John D. Dingell
The Honorable Fred Upton
The Honorable Ron Klink
The Honorable Michael Bilirakis
The Honorable Sherrod Brown

American Medical Association

Response to Representative Bliley on the National Practitioner Data Bank

12/22/99

1. Please provide the views of the American Medical Association on whether there is under-reporting to the NPDB due to covered entities: a) failing to comply with statutory reporting requirements; b) failing to aggressively pursue disciplinary actions; or c) deliberately attempting to impose disciplinary sanctions designed to avoid the statutory reporting requirements. Please provide documentation to support your conclusions. If your answer to any of the above subparts is in the affirmative, please provide your views on what can be done to improve the under-reporting problem.

Under Section 423(a)(l)(C) of the Health Care Quality Improvement Act of 1986, the AMA is required to report to the Board of Medical Examiners "a professional review action which adversely affects the membership of a physician in the society." The AMA, through its Council on Ethical and Judicial Affairs, has complied and will continue to comply with this reporting requirement. The AMA has not performed an assessment on whether there is under-reporting to the NPDB by other entities required to report under the Health Care Quality Improvement Act of 1986. The AMA has no data upon which to assess whether covered entities have failed to aggressively pursue disciplinary actions or whether there have been deliberate attempts to avoid the reporting requirements.

2. Please provide the views of the American Medical Association on whether the statute authorizing the NPDB (42 U.S.C. 1110 1 - 11152) should be changed to require that all disciplinary actions taken by a hospital or other health care entity against a doctor or dentist (irrespective of the time period in which the clinical privileges are adversely affected) be reported to the NPDB.

The NPDB was designed to provide relevant data for health care professional credentialing and state licensing purposes. The AMA is concerned that requiring covered entities to report suspensions of less than 30 days would increase costs to hospitals and practitioners, increase the paperwork burden for the NPDB, and produce no beneficial information for querying entities. If the reporting threshold is too low, events reported to the NPDB would not be useful indicators of a potential problem. In addition, such a low threshold would be a disincentive for peer review.

3. Please provide the views of the American Medical Association on whether the statute authorizing the NPDB should be changed to impose additional sanctions on those covered entities which fail to comply with statutory reporting requirements.

The AMA has not performed an assessment on whether covered entities have failed to comply with statutory reporting requirements. Assessing additional sanctions such as monetary penalties against hospitals, managed care organizations, group practices, and state licensing boards may result in less money spent on patient care and patient protection mechanisms.

4. Please provide the views of the American Medical Association on whether there is full compliance by hospitals with statutory requirements to query the NPDB about doctors or licensed health care practitioners before hiring them. Please provide documentation to support your conclusions. If your view is that there is not full compliance, please provide suggestions to achieve full compliance.

The AMA has not performed an assessment of whether there is full compliance by hospitals required to query the NPDB about physicians or licensed health care practitioners.

5. Please provide the views of the American Medical Association on whether the statute authorizing the NPDB should be changed to impose additional sanctions on those hospitals which fail to comply with the statutory requirement to query the NPDB about doctors or licensed health care practitioners before hiring them.

The AMA has not performed an assessment on whether hospitals are facing sanctions under the Health Care Quality Improvement Act of 1986, the Medicare and Medicaid Anti-Fraud and Abuse amendments, or the False Claims Act because of failure to query the NPDB about physicians or licensed health care practitioners before hiring them or granting them clinical privileges.

6. Please identify what efforts the American Medical Association has made to inform its members of the requirements of the NPDB.

The AMA utilizes several means to inform all physicians and medical students of the requirements of the Health Care Quality Improvement Act of 1986, including the NPDB. Our internet site includes information on the NPDB. In addition, the AMA's editorially independent publications, *American Medical News*, and *Journal of the American Medical Association* report on NPDB developments and publish NPDB related articles. Further, AMA staff is available to respond to inquiries from physicians relating to the NPDB.

7. Please provide the views of the American Medical Association on how you may improve upon your efforts to inform members of the requirements of the NPDB.

The AMA constantly strives to inform all physicians of the extremely complex and overwhelming number of federal and state laws and regulations, including the NPDB. An action plan would be devised and implemented if our ability to keep our members informed were found to be insufficient.

8. Please provide the views of the American Medical Association on whether the NPDB should include information relating to the criminal convictions of health care practitioners. In your answer, please assess the importance and relevance of such information, the current availability of this data, the usefulness of having such information available via a single source, and how the current difficulty in obtaining such information affects the quality of health care.

Criminal convictions are generally available as a matter of public record, and if they result in an exclusion from the Medicare program, the exclusion is listed by HCFA on its inter-net site. In addition, Congress passed and the President signed into law the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which established the Health Integrity and Protection Data Base (HIPDB). HIPAA requires state and federal governments and health plans to report adverse actions to the HIPDB, including most federal or state criminal and civil convictions and other administrative actions. The Administration stated in its October 26, 1999, Final Rule that the same federal agency that oversees the NPDB will administer the HIPDB. The regulations broadly define the criminal convictions that must be reported to the HIPDB. Thus, including criminal convictions in the NPDB would be redundant.

9. In the event that the NPDB were to include information relating to the criminal convictions of health care practitioners, please provide the views of the American Medical Association on whether such information should be made available to the public via the NPDB or another federal data bank. In your answer, please assess the relevance of such information to consumers to enable them to make informed health care decisions, the current availability of such data to consumers, the usefulness of having such information available to the public via a single source, and how the current difficulty encountered by the public in obtaining such information affects the quality of health care.

Not only are criminal convictions generally available as a matter of public record, but the HIPDB was established to collect data on criminal and civil convictions and other adverse administrative actions The Administration has moved to expedite the HIPDB implementation process by stating in its October 26,1999, Final Rule that it will begin immediate implementation. Because the HIPDB just became operational, it is not yet possible to assess its effectiveness. However, creating a duplicate data bank through the NPDB would be both premature and redundant

10. Please provide the views of the American Medical Association on whether hospitals should be required to query the NPDB before hiring all medical residents and interns. In your answer please identify the quantity and types of medical care provided by these categories of persons, what affect such a requirement might have on health care quality, and whether such information relating to medical residents and interns should also be released to the public.

Medical residents and interns are under the supervision of and take direction from attending physicians. To ensure quality and protect patients, hospitals that run residency and intern programs accept such physicians based primarily on medical school records, references, and performance reviews. Existing mechanisms if properly employed by hospitals should be sufficient to ensure patient safety.

11. Please provide the views of the American Medical Association on whether information relating to disciplinary actions (adverse licensure actions, adverse clinical privileges actions, and adverse professional society membership actions) taken against health care practitioners currently reported should be made available to the public via the NPDB or another federal data bank. In your answer, please assess the relevance of such information to consumers to enable them to make informed health care decisions, the current availability of such data to consumers, the usefulness of having such information available to the public via a single source, and how the current difficulty encountered by the public in obtaining such information affects the quality of health care.

The AMA supports the goal of preventing physicians from moving state to state or hospital to hospital without disclosure of peer reviewed adverse actions taken against them. We are also a national leader in the effort to increase patient safety and reduce health system errors.

The NPDB was designed to provide data for health care professional credentialing and state licensing purposes. Congress recognized that only credentialing and licensing entities have the resources needed to evaluate NPDB reports and analyze how the reports reflect on the competency of health care professionals. Congress has reiterated its intent to restrict access to the NPDB on many occasions The President's Quality Commission recently concurred. In addition, HCFA recently set forth in its October 26, 1999, Final Regulation that an even broader array of negative administrative actions than those listed above would be reportable to the HIPDB.

One of the country's foremost scholars on patient safety issues, Dr. Lucian Leape, in an article entitled, "Errors in Medicine," advocated a systematic approach to patient safety-as opposed to the NPDB's misguided focus on individuals-to create incentives for "flushing out" rather than hiding mistakes that may cause patient injury. (see, 272 JAMA 185 1 (1994)).

Opening the NPDB could inhibit health care quality initiatives. In 1999, the President's Quality Commission released its final report on improving and sustaining the quality of health care in the United States. The Commission considered and rejected providing unrestricted access to the NPDB as a means to improve quality. The Commission stated that "current systems to reduce or prevent errors in the provision of health care services tend to focus too much on individual practitioners and not enough on system problems" (p. 155). The Commission recommended that steps be taken to focus on determining the causes of error.

The AMA supports other avenues to pursue patient safety such as the National Patient Safety Foundation (NPSF). In 1997, the AMA and other health care leaders launched the NPSF to improve patient safety in the delivery of health care. The NPSF is an unprecedented partnership of health care practitioners, institutional providers, health product manufacturers, researchers, legal advisors, patient/consumer advocates, regulators, and policy makers committed to making health care safer for patients.

Focusing on the people in the health care system alone, and blaming them when an error occurs, prevents investigators from discovering the systemic root of the problem, which must be identified to prevent future errors. The NPDB is based on the assumption that human behavior in isolation is the cause of errors, a conclusion that is contrary to the IOM report's recommendations.

12. Please provide the views of the American Medical Association on whether information relating to malpractice payments by health care practitioners currently reported should be made available to the public via the NPDB or another federal data bank. In your answer, please assess the relevance of such information to consumers to enable them to make informed health care decisions, the current availability of such data to consumers, the usefulness of having such information available to the public via a single source, and how the current difficulty encountered by the public in obtaining such information affects the quality of health care.

The AMA vehemently opposes unrestricted public access to the NPDB because the NPDB system for collecting medical liability settlements and verdicts for the purpose of tracking problem physicians is a fatally flawed and an exceedingly inaccurate measure of the competence of a physician. Inclusion in the NPDB does not indicate that a physician has provided substandard care. Even some of our nation's finest physicians who specialize in high-risk cases are involved in settlements.

Malpractice data generated by the NPDB are incomplete, unreliable, and misleading. Malpractice claims seldom correlate with findings of negligent care in the medical record. Thus, reports made to the NPDB on paid malpractice claims provide, at best, an incomplete and haphazard indicator of a practitioner's competence or quality. The Health Care Quality Improvement Act of 1986 acknowledges that malpractice payments do not indicate that malpractice has occurred. Section 427(d) states:

> Interpretation of Information.-In interpreting information reported under this part, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.

The NPDB makes no adjustment for high risk or cutting edge medical procedures. Each day many people would die or become severely incapacitated if it were not for the high-risk medical procedures of dedicated and very capable physicians. High-risk obstetrics, open heart surgery, and neurological surgery to relieve the effects of Parkinson's Disease are just a few examples of commonly used high risk procedures. Only the most highly qualified and competent physicians are willing to perform such high-risk procedures that offer the only hope for relief of debilitating symptoms or life-threatening conditions. The NPDB information would be flawed and misleading without consideration of the risks involved in these procedures. Unrestricted public access would lead to unfair scrutiny of some of our nation's most talented physicians.

Also, advances in medicine are made only by utilizing new procedures and drugs. Someday these "cutting edge" procedures will be as common as yesterday's new innovations. But, for the same reasons as above, these pioneering physicians could be unfairly evaluated by a systematic release of gross settlement results.

Further, public exposure of raw NPDB data may decrease the quality of care by fueling the public misperception that physicians who settle malpractice claims are "bad doctors." Quality management scholars know that this misperception actually impedes the ability to improve patient safety by creating incentives to "hide" mistakes. The real key to maximizing patient safety is to develop systems that incorporate incentives for revealing mistakes Opening the NPDB to the public scrutiny is an anathema to this objective.

13. Please provide the views of the American Medical Association regarding the efforts of some states, such as Massachusetts and California, to provide information relating to medical malpractice payments and disciplinary actions of health care practitioners to the general public via the Internet.

The AMA has not studied the efforts in Massachusetts and California.

14. Please provide the views of the American Medical Association on whether the public would support the release of information relating to health care practitioner criminal, disciplinary and malpractice records from the NPDB.

The AMA has no basis on which to assess the public's support for the release of statutorily confidential NPDB information.